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Nos. 98-1513 and 98-1526

In The

Supreme Court of the United States

REDBUD COMMUNITY HOSPITAL,
ADVENTIST HEALTH, INC.,

Petitioners,

vs.

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF CALIFORNIA, DAVID BURROWS, RHODA THOMAS,

Respondents.

and

WOLFGANG SCHUG, M.D.,

Petitioner,

vs.

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs and surviving parents of Cody Burrows,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF AMICI CURIAE CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA HEALTHCARE ASSOCIATION, CALIFORNIA ACADEMY OF FAMILY PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS AND ITS CALIFORNIA CHAPTER, AND JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS IN SUPPORT OF PETITIONS FOR WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* AND *AMICI CURIAE BRIEF* IN SUPPORT OF PETITIONS FOR WRIT OF CERTIORARI

The California Medical Association, the California Healthcare Association, the California Academy of Family Physicians, the American Medical Association on its own behalf and on behalf of the 45 state medical associations which comprise the American Medical Association/ State Medical Society Litigation Center, the American College of Emergency Physicians and its California Chapter, and the Joint Commission on Accreditation of Healthcare Organizations (*"amici"*) hereby respectfully move for leave to file the attached brief of *amici curiae* in support of petitioners' Petitions for Writ of Certiorari in this case. The consent of the attorneys for the petitioners have been obtained. Respondents have refused to consent. The letters of consent we did receive have been filed separately with the court in this case.

All of *amici* are committed to, among other things, assuring the quality of health care in this country. The interest of *amici* in this case arises from the fact that the holdings below threaten confidentiality protections for peer review records and proceedings, and therefore threaten the quality of health care delivered in this country. Medical peer review is essential to assure physicians and other health care providers deliver quality health care and is interwoven throughout the health care licensing and accreditation standards, such as those promulgated by *amicus* Joint Commission and Accreditation of Healthcare Organizations. Any holding that fails to apply confidentiality protections for records or proceedings of

medical peer review bodies threatens to chill the willingness of practitioners to become involved in the evaluative process so essential to successful peer review.

Amici move for leave to file this brief in support of the Petition for Writ of Certiorari in order to more fully describe the medical peer review system in operation throughout the nation and highlight the potential crippling effects the lower court's ruling will have, if left to stand, on its successful functioning.

Respectfully submitted,

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California Academy of Family Physicians
California Healthcare Association
American College of Emergency Physicians and its California Chapter
American Medical Association on its own behalf and on behalf of 45 State Medical Associations
Joint Commission on Accreditation of Healthcare Organizations

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BRIEF OF *AMICI CURIAE*

This brief of *amici curiae*[1] is filed in support of the Petition for Writ of Certiorari filed by Wolfgang Schug, M.D., Redbud Community Hospital and Adventist Health, Inc. and is submitted on behalf of the California Medical Association, the California Healthcare Association, the California Academy of Family Physicians, the American Medical Association and the forty-five state medical associations and societies that are members of the AMA State National Society Litigation Center, the American College of Emergency Physicians and its California chapter, and the Joint Commission on Accreditation of Healthcare Organizations (herein referred to collectively as *"amici"*).

INTEREST OF *AMICI CURIAE*

The California Medical Association (CMA) is a nonprofit incorporated professional association of more than 30,000 physicians practicing in the state of California. CMA's membership includes most of the California physicians who are engaged in the private practice of medicine,

[1] All the parties except Respondents have consented to the filing of this brief. The letters of consent from all of the Petitioners have been filed with the Clerk of the Court. Counsel for a party did not author this brief in whole or in part. A draft of the brief was submitted to counsel for petitioner Wolfgang Schug, M.D., for review and comment. No person or entity, other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

in all specialties. The CMA's primary purposes are: " . . . to promote the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession. . . . "

The California Healthcare Association (CHA) is a non-profit trade association representing more than 540 hospitals. CHA membership includes public, private, non-profit and proprietary hospitals which are required by law to maintain medical staffs which engage in peer review. CHA is dedicated to serving the public's health care needs.

The California Academy of Family Physicians (CAFP) is a medical specialty society with more than 6,800 members. The mission of CAFP is to enhance, strengthen, and promote the specialty of family medicine, to promote professional and personal growth for its members, and to advocate for family centered care for all Californians. Family physicians are residency-trained primary care specialists who are able to treat a wide variety of illnesses and conditions and coordinate the care their patients receive from other physicians. Family physicians play an essential role in today's health care system, and are more likely to locate their practices in urban or rural underserved areas than physicians in other medical specialties.

The American College of Emergency Physicians (ACEP) is the largest national professional organization representing the specialty of emergency medicine with more than 19,800 members. ACEP exists to support quality emergency medical care and to promote the interests of emergency physicians. The California Chapter of ACEP ("CAL/ACEP") is by far the largest state chapter

of emergency physicians with almost 2000 members practicing in approximately 400 hospitals.

The American Medical Association (AMA), a nonprofit corporation, is an association of approximately 275,000 physicians who practice throughout the United States. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these still remain its core purposes. Its members practice in all fields of medical specialization, and it is the largest medical society in the United States.

The AMA files this brief as a representative of the American Medical Association/State Medical Society Litigation Center ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts. Forty-five state medical societies join the AMA as members of the Litigation Center. The member organizations, in addition to the AMA, are: Medical Association of the State of Alabama, Alaska State Medical Association, Arkansas Medical Society, California Medical Association, Colorado Medical Society, Connecticut State Medical Society, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, Hawaii Medical Association, Illinois State Medical Society, Indiana State Medical Association, Iowa Medical Society, Kansas Medical Society, Kentucky Medical Association, Louisiana State Medical Society, Maine Medical Association, Massachusetts Medical Society, Michigan State Medical Society, Minnesota Medical Association, Mississippi State Medical Association, Missouri State Medical Association, Montana

Medical Association, Nebraska Medical Association, New Hampshire Medical Society, Medical Society of New Jersey, New Mexico Medical Society, Medical Society of the State of New York, North Carolina Medical Society, North Dakota Medical Association, Ohio State Medical Association, Oklahoma State Medical Association, Oregon Medical Association, Pennsylvania Medical Society, Rhode Island Medical Society, South Carolina Medical Association, Tennessee Medical Association, Texas Medical Association, Utah Medical Association, Vermont State Medical Society, Washington State Medical Association, West Virginia State Medical Association, State Medical Society of Wisconsin, and Wyoming Medical Society.

The Joint Commission on Accreditation of Healthcare Organizations ("JCAHO" or "Joint Commission") is the leading health care accrediting body in the world, evaluating and accrediting nearly 20,000 health care organizations and programs in the United States. An independent, not-for-profit organization, the Joint Commission is the nation's predominant standards-setting and accrediting body in health care. Since its founding in 1951, the Joint Commission has had one basic purpose: to improve the quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. The Joint Commission accredits almost 11,000 of the nation's hospitals and home health agencies, and more than 7,000 other health care organizations, including health care networks, clinical laboratories and ambulatory care, long term care and behavioral health care organizations. For more than four decades, the Joint Commission has developed state-of-the-art standards and

evaluated the compliance of health care organizations against them.

A. *Amici* CMA, CHA, CAFP, CAL/ACEP, AMA, ACEP and JCAHO Urge this Court to Grant the Petition for Writ of Certiorari in This Case.

Amici strongly support the petition in this case because it raises an issue of profound importance: the preservation of the system of confidential medical peer review which functions in every state in the nation to provide significant protection of the public health. This Court should grant review to create a federal medical peer review immunity, or in the alternative require as a matter of comity that deference always be granted to state-created peer review privileges in civil lawsuits alleging EMTALA or other violations of the standard of care. Discovery of medical peer review records must be prohibited in such cases, whether cloaked under EMTALA or other federal statutes, to assure the nations' system of medical peer review is not crippled by a loss of confidentiality. Such a ruling would also reduce the likelihood of plaintiffs forum shopping what are in essence medical malpractice cases recast under federal theories.[2]

In state courts, statutes like that at issue in this case, California Evidence Code Section 1157 ("Section 1157"),

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[2] *See, e.g. Barris v. County of Los Angeles*, 20 Cal. 4th 101, 83 Cal.Rptr. 2d 145 (1999) in which the California Supreme Court ruled that an EMTALA claim based on a failure to stabilize a patient's emergency medical condition, is "based on professional negligence" and thus subject to California's Medical Injury and Compensation Reform Act like any other case alleging medical malpractice.

prohibit civil discovery of medical peer review records. Section 1157 protects peer review information from disclosure through civil discovery as do similar state statutes throughout the nation. Creation of a federal medical peer review privilege against discovery, or a ruling requiring deference to state-created protections based on principles of comity, is absolutely necessary to avoid irreparable harm to the profoundly important public policy uniformly mandated by virtually all of the 50 state legislatures,[3] namely, that the confidentiality of the medical peer review system in operation throughout the country be protected. The protection of that system, and the crucial quality improvement functions it performs in the nation's hospitals and other health facilities, requires that records falling within the ambit of immunity statutes like Section 1157 not be subject to compelled disclosure in any civil proceedings, however denominated, challenging the quality of medical care provided.

B. Permitting Compelled Disclosure of Medical Peer Review Records in EMTALA Claims Would Profoundly Chill the Nation's Physicians' Willingness to Participate Candidly in Peer Review With Little or No Countervailing Benefit to the Search for Truth.

With at least the perception among members of the medical profession that increasing numbers of EMTALA

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[3] Recent case law in Kentucky appears to have diminished the confidentiality protections for peer review records and proceedings embodied in that state's peer review statute. *See Sisters of Charity Health Systems, Inc. v. Raikes (Dones)*, 984 S.W.2d 464 (1998).

cases are being filed,[4] the chilling effect the threat of compelled disclosure of peer review records in such cases on physicians' willingness to participate in candid and meaningful peer review becomes ever more pronounced. Physician participation as medical peer reviewers on hospital medical staffs and in other settings is generally an entirely volunteer endeavor, affording no additional pay, sometimes incurring lost income for time taken from practice, and offering little tangible reward other than the knowledge that the profession and patient safety are enhanced by continuous and rigorous peer review. Disclosure of peer review records for purposes of federal EMTALA cases (and any pendent state claims) raises the specter that peer review records containing candid critiques by identifiable physician reviewers will be placed into evidence for the world to see. The reluctance of physicians to "serve up" their hospitals and peers in this way is obvious and profound, particularly given the potential such information will be taken out of the collegial and constructive context in which it was offered, whether by the plaintiffs' attorneys or the subject physician. Indeed, notwithstanding broad immunities from liability for peer review communications, lawsuits brought by the affected health care providers are not unheard of when confidential communications are made public.[5] Such disclosures may also cause discord between people

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[4] *See, e.g., Roberts v. Galen of Virginia, Inc.*, 525 U.S. ___, 142 L.Ed.2d 648 (January 13, 1999) (Recovery for violation of EMTALA provision (42 U.S.C. § 1395dd(b)) held not to require proof that hospital acted with improper motive in failing to stabilize patient.)

[5] *See, e.g., Dorn v. Mendelzon*, 196 Cal.App.3d 933, 242 Cal.Rptr. 259 (1987).

who may of necessity continue working together very closely. Further, in the absence of a discovery immunity, more plaintiffs would seek to depose or call physician reviewers themselves to trial, adding further to the chilling effect on physician participation in the various states' medical peer review systems.

There is no countervailing evidentiary benefit which would justify this disruption. Peer review records sought by plaintiffs in cases challenging the quality of medical services provided are created by an evaluative process performed after-the-fact. In these cases, application of the immunity statute to prohibit access to peer review records does nothing to preclude plaintiffs' own evaluation of the evidence they gather elsewhere through discovery, such as the medical records. To deny the requested discovery is in no way inconsistent with Congress' goals in enacting EMTALA, or with other federal policy.

The public policy supporting the discovery immunity for medical peer review is thus far stronger than it was for the academic peer review at issue in *University of Pennsylvania v. Equal Employment Opportunity Commission*, 493 U.S. 182, 107 L.Ed. 2d 571 (1990). In cases alleging discriminatory faculty tenure decisions, the faculty peer review information may often be the best, if not the only evidence available to prove the claim. *See University of Pennsylvania v. EEOC*, 493 U.S. at 193; 107 L.Ed. 2d at 584-585. On the other hand, medical peer review information will be, at most, a potential source of secondary evidence in EMTALA and similar cases which do not challenge the fairness of the peer review process itself. Medical peer review information in such cases is much more like the after-the-fact psychotherapy records this

Court protected from discovery in *Jaffee v. Redmond*, 518 U.S. 1, 135 L.Ed. 2d 337 (1996). Indeed, this Court's admonition in the *Jaffee* case is equally applicable with respect to medical peer review: "[w]ithout a privilege, much of the desirable evidence to which litigators . . . seek access . . . is unlikely to come into being." *Jaffee v. Redmond*, 135 L.Ed. 2d at 346.

C. The Strong Public Policy Considerations Favoring Open and Candid Medical Peer Review Would Be Severely Frustrated if the States' Various Peer Review Immunity Statutes Could Be Bypassed by Filing in Federal Court.

Statutes like California Evidence Code Section 1157 promote important public policy considerations. Specifically, they reflect a recognition of two essential truths: (1) that diligent performance of medical quality assessment and peer review is essential to the public health, and (2) that medical quality assessment and peer review will fail in the absence of confidentiality. *See, e.g., Matchett v. Superior Court*, 40 Cal.App.3d 623, 115 Cal.Rptr. 317 (1974). In *Matchett*, a California appellate court noted the critical need for medical staff peer review committees in protecting the public by policing the profession, and supported the rationale for the discovery immunity stating:

> In an accredited hospital, the organized medical staff is responsible to the hospital governing body for the quality of in-hospital medical care; it evaluates the qualifications of applicants and holders of staff privileges; it recommends appointment, reappointment, curtailment and exclusion from staff privileges; it provides peer group methods for reviewing basic medical,

> surgical and obstetrical functions. [citations omitted] . . . [T]he quality of in-hospital medical care depends heavily upon the committee members' frankness in evaluating their associates' medical skills and their objectivity in regulating staff privileges. Although composed of volunteer professionals, these committees are affected with a strong element of public interest.
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> * * *
>
> ***Section 1157 was enacted upon the theory that external access to peer investigations conducted by staff committees stifles candor and inhibits objectivity.*** It evinces a legislative judgment that the quality of in-hospital medical practice will be elevated by armoring staff inquiries with a measure of confidentiality.

Matchett, supra, 40 Cal. App. 3d at 628-29; emphasis added.

The *Matchett* court thus found that:

> Section 1157 represents a legislative choice between competing public concerns. It embraces the goal of medical staff candor at the cost of impairing plaintiffs' access to evidence.

Matchett, supra, 40 Cal.App.3d at 629.

Courts have repeatedly reaffirmed the need for medical peer review discovery immunities to insure that medical peer review be conducted with full candor, without the chilling threat of potential discovery of the peer review proceedings. For example, in *Alexander v. Superior Court,* 5 Cal.4th 1218, 23 Cal.Rptr.2d 397 (1993), the California Supreme Court noted that allowing discovery of peer review information submitted to medical staff committees from outside physicians would be detrimental to patients. As the Court stated:

> The immediately predictable result will be that physicians . . . will cease providing . . . negative information or constructive criticism. . . . Without this frank exchange of information, medical staffs will have no legal grounds upon which to initiate corrective action (such as restricting privileges or requiring monitoring or further education) that could be critical to the protection of patients. Clearly such a result would be contrary to the Legislature's intent in enacting Section 1157.

Alexander v. Superior Court, 5 Cal.4th at 1227-28, 23 Cal.Rptr.2d at 403.

The need to protect the confidentiality of medical peer review records from compelled discovery in civil litigation has also been recognized by federal courts. As discussed in the leading federal case recognizing a privilege for medical peer review:

> Confidentiality is essential to effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care. . . . Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.

Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (D.D.C. 1970), aff'd, 479 F.2d 920 (D.C. Cir. 1973). *See also Weekoty v. United States*, 30 F.Supp.2d 1343 (D.N.M.) 1998.

These decisions are informed by the conclusion of Legislatures throughout the country that a comprehensive, ongoing system of rigorous medical peer review is

necessary to the health and welfare of the people of this nation. Indeed, such activity is a principal patient protection mechanism in hospitals throughout the country. A comprehensive quality assurance process is critical to the identification and resolution of potential or ongoing problems, as well as to the identification of opportunities to improve patient care. Protocols and procedures must be continuously analyzed and revised to reflect new information and technologies. Current assessment of the clinical performance of physicians and other health care providers is crucial in order to provide appropriate education and training where warranted and to identify impaired or deficient individuals *before* patients are injured.

To be effective, this review function must be performed by individuals who have the expertise necessary to evaluate the quality of medical care provided and the ability to implement remedial action in a timely manner. An effective medical peer review system provides the optimal solution. Members of medical staffs have both the expertise and familiarity with the facilities, physicians and other health care providers involved necessary to ferret out problems and take corrective action. With the promise of confidentiality, physicians and other health care providers under review are also free to explain their perspectives on problem cases and contribute to a constructive dialogue.

Thus, like many states, the California Legislature and the Department of Health Services (DHS) require, as a condition of licensure, that each California hospital have an organized, self-governing medical staff, which is responsible for performing a number of quality assurance functions. (Business and Professions Code § 2282; Health

& Safety Code § 1250; 22 California Code of Regulations ("C.C.R.") §§ 70701(a)(1)(F), 70703(a).) Medical peer review is thus crucial in three major areas: (1) credentialing, (2) quality assessment, and (3) ongoing corrective action.

1. Credentialing. The medical staff is responsible for protecting the quality of patient care through the credentialing of medical staff applicants and members. Credentialing is a process through which the training and experience of applications/reapplicants for clinical privileges are scrutinized in order to assure the initial and on going competence of every physician, dentist, podiatrist and, in some cases, clinical psychologist who is granted privileges to practice in the hospital, *See generally, Unterthiner v. Desert Hospital District*, 33 Cal.3d 285, 188 Cal.Rptr. 590 (1983). In California, this process must include "formal procedures for the evaluation of staff applications and credentials, appointments reappointments, assignment of clinical privileges, appeal mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate." 22 C.C.R. § 70703(b). Furthermore, these credentialing procedures msut be:

> [D]esigned to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter. (22 C.C.R. § 70701(a)(7).)

2. Quality Assessment. Equally important as its credentialing responsibility is the medical staff's responsibility to continuously monitor the quality of care rendered in the hospital. California hospital licensing regulations specifically require that the medical staff maintain one or more committees formally organized to monitor the care and treatment rendered to hospitalized patients. (22 C.C.R. § 70203(d).) For example, the medical staff is obligated to perform the following patient care review functions on a regular basis:

a. Medical Records Review: the evaluation of medical records for their timely completion and adequate reflection of the patient's condition and treatment which is necessary to ensure that others will be able to assume the patient's care if required. (22 C.C.R. §§ 70703(d), 70749 and 70751.)

b. Surgery Review: the evaluation of surgeries performed to determine whether the surgery was both indicated and properly executed. (22 C.C.R. §§ 70703(d) and 70223(b),(h).)

c. Utilization Review: the evaluation of the allocation of the hospital's health care resources to monitor and address overutilization, underutilization and inefficient scheduling. (22 C.C.R. § 70703(d).)

d. Infection Control and Antibiotic Usage Review: the evaluation of the clinical use of antibiotics and the ongoing prevention, surveillance, and control of infections from whatever source, throughout the hospital. (22 C.C.R. §§ 70703(d) and 70739.)

e. Pharmacy and Therapeutics Review: the evaluation of pharmacy and therapeutics

practice and the development of a drug formulary and policy relating to the safe handling, distribution, and administration of drugs. (22 C.C.R. §§ 70703(d) and 70263.)

f. **Interdisciplinary Practice Committee:** the development of written "standardized procedures" and supervision requirements which permit nurses and physicians' assistants to perform extended functions in the hospital. (Business and Professions Code § 2725; 22 C.C.R. §§ 70706 *et seq.*)

g. **Clinical Laboratories/Radiology/Anesthesiology Review:** the evaluation and the development of procedures governing clinical laboratory, radiology and anesthesiology practice. (22 C.C.R. §§ 70233, 70243, and 70253.)

h. **Disaster Planning:** the development of a written disaster and mass casualty program. (22 C.C.R. § 70741.)

i. **Hospital Safety Planning:** the development of a written program to deal with internal disasters such as fires. (22 C.C.R. §§ 70743, 70745 and 70746.)

j. **Continuing Education:** the development of and participation in a mandatory, ongoing program of continuing education addressing the problems discovered during the foregoing patient care review activities. (22 C.C.R. § 70703(g).)

3. **Corrective Action.** The medical staff also engages in ongoing monitoring of each medical staff member and takes appropriate action, where necessary, to correct or address any problems which might pose a danger to patients. Thus, if in the course of its credentialing or

patient care review activities, the medical staff has reason to believe that a medical staff member may pose a danger to patients, the medical staff will conduct an investigation. Appropriate medical staff departments or committees, including committees with special expertise in dealing with substance abuse or physical or mental impairment, are generally readily available to provide appropriate education or other rehabilitation. In the vast majority of cases, this process allows the medical staff to identify and resolve problems before any patient harm occurs. Where such intervention is not successful, or the medical staff is otherwise of the opinion that the physician or other health care provider should have his or her privileges to practice in the hospital restricted or revoked, a formal hearing process is typically necessary.

These activities, and by implication the necessity of the discovery immunity, are aptly described by one California appellate court as follows:

> These committees perform investigations of physicians applying for staff privileges, establish standards and procedures for patient care, audit each surgery performed, and investigate discrepancies between preoperative and postoperative diagnoses. *The committees compile records and evaluations and engage in frank discussions about the performance and competence of their peers.* Should the committee find a peer to be incompetent, a report and recommendation is made to administrators, who may then take action to revoke, limit, or deny medical staff privileges.

California Eye Institute v. Sup. Ct., 215 Cal.App.3d 1477, 264 Cal.Rptr. 83 (1989), quoting Comment, 24 *Santa Clara L. Rev.* 661, 670, emphasis added.

California is not unique in its recognition and use of comprehensive medical staff quality assurance programs as outlined above. While this is the system in place in the state in which this case arose, similar laws, regulations, or accreditation standards mandate similar peer review activity in most of the nation's hospitals. Indeed, the standards established for the accreditation of hospitals nationally by the Joint Commission impose virtually identical requirements for medical peer review. *See* JCAHO *Comprehensive Accreditation Manual for Hospitals* (1999). Similar peer review activities are also mandated by Congress as a condition for payment under Medicare (42 U.S.C. § 1395x (e) and (k)) and Medicaid (42 U.S.C. § 1396a(a)(9)(A), (19), (26)).

It is important to note that organized medical staff peer review, as prescribed in the JCAHO Standards and as accomplished in California and throughout the nation, was initiated as a *voluntary* activity.[6] The present JCAHO program began as a physician-sponsored effort, under the auspices of the American College of Surgeons, in 1918. Then, as now, the purpose of this activity has always been "the right care of the sick and the injured." Then, as now, the vast majority of medical peer reviewers devote untold

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[6] Nor is medical peer review limited to the hospital setting. Professional medical associations such as those participating as *amici* in this case also engage in medical peer review activity of critical importance to the delivery of quality health care, especially with respect to medical care provided in outpatient facilities or other situations in which the hospital medical staff is unable to provide appropriate review and feedback. These associations also play an important role in defining and monitoring professional ethics, another aspect of professional self-regulation which depends upon confidentiality.

hours of time and attention to this function, without any compensation whatsoever. These activities are performed in most cases by committees who meet early in the mornings, over the lunch hour, in the evenings, or on weekends as necessary to get the job done. It is detailed, demanding and often unpleasant work (e.g., when a physician's privileges to practice medicine in the hospital must be denied or restricted because the physician is unqualified or incompetent). In our litigious society, participation in the quality assurance/peer review process is fraught with legal peril as well. Statutory encouragement and protection of medical staff peer review has rightly followed.

D. The Quality of Emergency Medicine in This Country Will Suffer if Peer Review Records Can Be Obtained in Any Malpractice Claim filed as a Federal EMTALA Case.

Emergency medicine in many states constitutes the critical "safety net" for indigent patients as well as the working poor.[7] Peer review in this very difficult medical specialty is essential to maintain high quality medical services. Emergency physicians will be much less likely to engage in meaningful peer review activities knowing

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[7] Medicaid Access Group, *Access of Medicaid Recipients to Outpatient Care*, 330 New Eng. J. Med. 1426, 1430 (1994) (noting that many poor people have nowhere else to go other than hospital emergency departments); Robert S. Stern et al., *The Emergency Department as a Pathway to Admission for Poor and High-Cost Patients*, 266 JAMA 2238, 2238 (1992) ("Patients with lower socioeconomic status are more likely than other patients to use the emergency department as their means of access to the hospital.").

that a bad outcome in a case requiring review may also serve as the basis for a later malpractice case denominated as an EMTALA violation, in which their peer review efforts may be used against their hospital and peers, and about which they themselves may be deposed or called to the witness stand.

Nor are emergency medicine physicians the only ones who work in the emergency department. In the instant case, Dr. Schug is a family practice physician who works in the emergency room. Many specialties of physicians work in the emergency department, either covering emergency department shifts or serving "on-call" to the emergency department and responding to an emergency physician's request for help on a complex case. *Amici* have noted an increased difficulty in maintaining on-call specialty physician back-up panels in this country due primarily to poor or no compensation from either the patients or the managed care companies involved. An additional blow to the confidentiality of peer review records and information by permitting plaintiffs access through the "back door" of federal EMTALA claims can only further reduce the willingness of *all* physicians to serve "on-call" in emergency departments around the country.

As evidenced by the participation of *amici* representing a broad swath of the health care community, this case is of great national importance. For the foregoing reasons, as well as the reasons outlined in Dr. Schug's Petition for Writ of Certiorari, *amici* strenuously support the Petition in this case so the Court can make a reasoned judgment regarding the creation of a federal medical peer review privilege applicable in civil actions such as this or, in the

alternative, the application in federal court of state statutes protecting medical peer review information from discovery as a matter of comity.

Respectfully submitted,

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